DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Somerford Place

DATE SURVEY COMPLETED: April 17, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning April 11, 2017 and ending April 17, 2017. The facility census on the entrance day of the survey was 48 residents. The survey sample totaled 6 residents and was composed of five residents plus a subset of one resident. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations used in this state report are as follows:** **ED - Executive Director** **DON - Director of Nursing** **ADON – Assistant Director of Nursing** **RN - Registered Nurse** **LPN - Licensed Practical Nurse** **CNA – Certified Nurse Aide** **UAP – Unlicensed Assistive Personnel – an unlicensed staff member who receives training in order to assist with the self-administration of medications or administer medications in assisted living facilities.** **UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.**	Completion Date: September 30, 2017

Shenna Trotta, NHA / Executive Director 8/14/17

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3225.0 3225.8.0 3225.8.1 3225.8.1.4	**Assisted Living Facilities** **Medication Management** **An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member/support person.** **This requirement is not met as evidenced by:** Based on observation of assistance with self-administration of medication it was determined that the facility failed to ensure that one resident (R4) out of four residents sampled was assisted with the self-administration of eye drops according to facility policy. Findings include: Observations conducted on 4/12/2017 of assistance with self-administration of medication beginning at 8:30 AM revealed that E6 (CNA/UAP) donned gloves to assist R4 with the self-administration of eye drops without washing her hands and following assistance with the self-administration of oral medications for R4. In an interview with E2 (DON/RN#1)	1. R4 was not adversely affected by this practice. The LLAM certified tech was coached and counseled regarding the facility's policy about hand washing prior to gloving. 2. All residents who require assistance with the administration of eye drops are at risk with this practice. All LLAM certified aides will be reeducated on the hand washing policy and eye drop administration by the RSD or designee (RN/certified LLAM trainer) in August. RSD or designee will monitor eye drop assistance monthly to ensure accuracy and consistency until 100% compliant, then quarterly eye drop observations. If LLAM certified tech is not following proper procedure, 'on the spot' training will occur at the time of the deficient practice. 3. LLAM certified Aides will complete in-service review training on the facility's assistance with self-administration eye drop's policy. 4. The RSD or designee will witness a random two assisted self-administration eye drop passes monthly until 100% compliant and record in audit book for ED review. They quarterly checks per policy.

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	conducted on 4/12/2017 at approximately 11:15 AM it was confirmed that handwashing was required prior to gloving and assisting R4 with self-administration of eye drops. This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	
3225.9.0 3225.9.5 3225.9.5.1	**Infection Control** **Requirements for tuberculosis and immunizations:** **The facility should have on file the results of tuberculin testing performed on all newly placed residents:** **This requirement is not met as evidenced by:** Based on review of the clinical record and staff interview it was determined that the facility failed to ensure that one resident (R3) out of four sampled had documented results of tuberculin testing upon admission and during his current two year stay at the facility. Findings include: Review of the clinical record revealed no documentation of tuberculin testing and results of tuberculin testing for R3. Further review of the clinical record revealed that the initial UAI (Uniform Assessment Instrument) completed	1. R3 was not adversely affected by this practice.R3 or representative will be offered again if he would like the PPD test. If resident refuses the resident or representative will be educated on the risks/benefits of the testing and document in the chart. The resident will be offered the test every year if the resident/representative changes his/her mind. 2. All residents who have not had an initial PPD test prior to admission are at risk with this practice. An audit of all active residents' Immunization Record will be conducted to ensure all residents have had a PPD test documented prior to admission. Any resident identified will have the test offered again and if refused will be educated on the risks/benefits of the test, document the chart, and place on a tickler file to offer again in one year. 3. All prospective residents to the facility will not be admitted until the PPD test and results are documented in the pre move in paper work. The Admission

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	upon admission of R3 to the assisted living facility on 10/28/2015 and the annual UAI completed 11/28/2016 failed to include the actual date and results of tuberculin testing. Additionally the clinical record revealed the facility form "Resident Immunization Record" included one recorded date, 7/19/15, and referred to a "c x r" (chest x-ray) without any documented findings. Review of the clinical record revealed no documented history of a positive tuberculin skin test or treatment and no results of actual tuberculin testing for R3. In an interview with E2 (DON/RN) on 4/17/2017 at 12:45 PM it was stated that R3 had refused tuberculin testing. This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	checklist tool has been updated to reflect the system change. All Residents who refused the PPD and had Chest X Ray in lieu of the testing will be placed in a tickler file to be offer the test each year if the resident or representative changes his or her mind about the test. The Regional Director of Health Services will train the RSD on the tickler file system. 4. The ED or designee will audit 50% of new admissions each month to ensure compliance and documentation until 100% compliant.
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (GRA or TB blood test) such as Quantiferon. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of**	1. No employees were adversely affected by this practice. E8 is still employed at the community. E8 will receive a two-

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	Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.	step PPD on 8-19-17 and results to be read 8-21-17.
3225.9.5.2.4	**A report of all test results shall be kept on file at the facility of employment.**	2. All employees have the potential to be affected by this practice. An audit will be conducted of all active employee files to ensure all employees received a two-step PPD at pre hire.
	This requirement is not met as evidenced by:	3. All new hires will not be scheduled for new hire orientation until the 2nd step ppd test has been completed. The Human Resource "new hire checklist" has been updated regarding this system change.
	Based on review of facility documentation and staff interview the facility failed to ensure that one staff member (E8) out of ten staff members sampled had received the pre-employment baseline two step tuberculin test. Findings include:	4. ED or designee will audit new hire files every month, times 3 months and/or until 100% compliant.
	Review of facility documentation revealed that E8 was hired on 4/27/2016 and received the initial tuberculin skin test on 4/7/2016. The result of the skin test was read and documented on 4/9/2016. However further review of facility documentation revealed the absence of the date and results of the second step of the baseline tuberculin skin test.	
	This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents as recommended by the**	

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	Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to document reasons for refusal and discussion of the health risks involving refusal of the influenza vaccine for one resident (R4) out of four sampled. Findings include: Clinical record review revealed that R4's refusal of the influenza vaccination was documented for the year 2016. However the facility failed to include documented reasons of R4's refusal and discussion of the health risks involving refusal of the influenza vaccine in the clinical record. This finding was reviewed with E1(ED), E2 (DON/RN#!) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	1. R4 was not adversely affected by this practice. The resident/representative will be reoffered the vaccine this influenza season. If the resident/representative refused the vaccine again, the resident/representative will be educated on the risks and benefits of refusing the vaccine. This refusal will be documented in the resident's chart with the reason for refusal and the discussion about the health risks for refusing the vaccine. 2. All residents who have refused the influenza vaccine are at risk for this practice. An audit of all resident's medical records will be conducted to identify any resident at risk for this practice. Any resident identified as refusing the influenza vaccine will be offered the vaccine again this influenza season and if refused will be educated on the risks/benefits of the vaccine and this will be documented in the resident medical record including the reason for refusal. 3. The nursing staff will be trained by the RSD or designee to document any resident that refuses these current and subsequent years on the reason why the resident/representative refused the influenza vaccine and how to educate and document the health risks of refusing the
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years,**	

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	or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless specifically, medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to document reasons for refusal and discussion of the health risks involving refusal of the pneumococcal vaccine for one resident (R4) out of four sampled. Findings include: Clinical record review revealed that documentation of the refusal of the pneumococcal vaccination for R4 was absent for the year 2016. Additionally the facility failed to document any discussion with R4 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R4 for refusal of the pneumococcal vaccine. This finding was reviewed with E1(ED),	vaccine. 4. RSD/designee will review immunization records post influenza season to ensure all refusal of the vaccine are documented as per policy until 100%. 1. R4 was not adversely affected by this practice. The resident/representative was reoffered the pneumococcal vaccine and the resident refused again. The resident/representative was educated on the risks and benefits of refusing the vaccine. This refusal was documented in the resident's chart. 2. All residents who have refused pneumococcal vaccine are at risk for this practice. An audit of all resident's medical records will be conducted to identify any resident at risk for this practice. Any resident identified as refusing the pneumococcal vaccine will be offered the vaccine again and if refused will be educated on the risks/benefits of the vaccine and this will be documented in the resident medical record. 3. All residents that refused the pneumococcal vaccine will be placed on a tickler file and reoffered every year. If refused will be educated about the risks/benefits of the vaccine and document in the chart. All new admissions will be reviewed by the Resident Service Director (RSD) for any refusal of the pneumococcal vaccine will

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	E2 (DON/RN) and E3 (DON/RN) on 4/17/2017 at approximately 2:20 PM.	offered again, educated on the risks/benefits of the vaccine and if refused will be documented in resident's medical records and will be placed on the tickler file. The RSD will be educated by the Regional Director of Health Services (RDH) on a tickler file system and the expectation for maintenance of said tickler system.
3225.11.0	**Resident Assessment**	
3225.11.4	**The resident assessment shall be completed in conjunction with the resident.**	
	This requirement is not met as evidenced by:	4. RSD/designee will review a random selection of five residents that are in the tickler file monthly to ensure appropriate documentation of refusal and education until 100% compliant.
	Based on clinical record review and staff interview it was determined that the facility failed to ensure that an annual UAI (Uniform Assessment Instrument) assessment was completed in conjunction with one resident (R3) out of four sampled residents. Findings include:	
	Review of the annual UAI (Uniform Assessment Instrument) dated 11/28/2016 revealed that it was incomplete and without the date and signature of R3 or his representative.	1. R3 was not adversely affected by this practice. The UAI has been updated, dated and signed by the resident's representative.
	This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	2. All residents have the potential to be affected by this practice. An audit will be conducted. Any resident identified with an incomplete UAI will be completed and reviewed and signed and dated with the resident and/or representative.
3225.13.0	**Service Agreements**	3. All UAIs are organized in a tickler file. The Regional Director of Health Services will educated RSD on the use of the tickler file and the expectations and for completing and ensuring signature from the resident/representative to remain complaint with this policy.
3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the**	

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	assisted living facility shall execute a revised service agreement, if indicated. **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility executed an annual service agreement without the date and signature of R3 or his representative. Findings include: Review of the revised annual service agreement dated 11/28/2016 revealed the absence of the date and the signature of Resident #3 or his representative. This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	4. ED or designee will audit 10% of UAIs in the tickler file to ensure completeness monthly until 100%. 1. R3 was not adversely affected by this practice. The Service Agreement has been updated and signed by the resident's representative. 2. All residents have the potential to be affected by this practice. An audit will be conducted. Any resident identified with an incomplete Service Agreement will be completed and reviewed, signed, and dated with the resident and/or representative.
3225.15.0	**Quality Assurance** **The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.** **This requirement is not met as evidenced by:** Based on review of facility documents and staff interview it was determined that the facility failed to track the	3. All Service Agreements are organized in a tickler file. The Regional Director of Health Services will educated RSD on the use of the tickler file and the expectations and for completing and ensuring signature from the resident/representative to remain complaint with the policy. 4. ED or designee will audit 10% of Service Agreements in the tickler file to ensure completeness monthly until 100%.

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	performance and measures of resident satisfaction. Findings include: In an interview conducted with E1 (ED) on 4/17/2017 at approximately 2:15 PM it was acknowledged that the results of any program developed to track performance and measures of resident satisfaction during the year 2016 were unavailable despite efforts to gather the requested information. This finding was reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	1. No residents were adversely affected by this practice. 2. All residents have the potential to be affected by this practice. A Resident Satisfaction Survey will be presented to all residents/families and the results will be brought to QAPI meetings.
3225.18.0 **3225.18.2**	**Emergency Preparedness** **Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement is not met as evidenced by:** Based on review of facility documents between April 2015 and March 2017 and staff interview it was determined that the facility failed to conduct fire drills on a quarterly basis for each shift and to maintain written records of attendance at documented fire drills. Findings include: Review of documented fire drills conducted between April 2015 and March 2017 revealed the facility lacked documentation of the performance of	3. The ED will be in-serviced by the Regional Director of Operations (RDO) on the yearly requirement of the satisfaction surveys and bringing the results to QAPI meetings. Satisfaction Surveys will be distributed annually and the results will be given to the ED for review. 4. ED/designee will conduct annual audits to ensure surveys have been distributed until 100% compliant.

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	fire drills and the attendance at such drills for all shifts and quarters for the years 2015 and 2016. Findings found between April 2015 and December 2015 revealed that no fire drills were recorded for the months of April 2015 and May 2015. Additionally the second quarter of 2015 revealed the absence of recorded fire drills for the 7-3 and 11-7 shifts. The facility also failed to maintain a written record of attendance at the documented fire drill for the month of August 2015. Further review of fire drills recorded between January 2016 and December 2016 also revealed no documentation of recorded fire drills for March 2016 and September 2016. Review of the first quarter of 2016 revealed the absence of a recorded fire drill for the 11-7 shift and no documentation of a recorded fire drill for the 3-11 shift during the third quarter of 2016. Additionally the facility failed to maintain a written record of attendance at the documented fire drill for the month of July 2016. These findings were reviewed with E1(ED), E2 (DON/RN#1) and E3 (DON/RN#2) on 4/17/2017 at approximately 2:20 PM.	1. No Resident was adversely affected by this practice. 2. All residents have the potential to be affected by this practice. A fire drill was completed on each shift with attendance documented. 3. The facility will devise a tickler file in where it will alert the Maintenance Director of the shift due for a fire drill. The Maintenance Director will be in-serviced on the tickler system by the ED. 4. The ED will audit the tickler file monthly until 100% compliance.

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